		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035741

Facility Name: LaHarpe-Davier Health Care Center

Address: 101 N. "B" Street, P.O. Box 547 (Number) LaHarpe (City) 61450 (Zip Code)

County: Hancock

Telephone Number: 217-659-3222 **Fax #** 217-659-3017

IDPA ID Number: 37-0619841002

Date of Initial License for Current Owners: 07/21/1922

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501 © 3	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Jamie Hull **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2003 to 09/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Jeffery G. Howd
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) James G. Hull, C.P.A. — Vice President
(Firm Name & Address) WDM Computer Services, Inc. — 1900 Harrison, Quincy, IL 62031
(Telephone) 217-228-1950 Fax # 217-222-6053

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 49

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	7,304	3,444		10,748	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,304	3,444		10,748	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.93%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
KID CARE (STOPPED IN 04),

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/04 Fiscal Year: 09/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	102,733	6,497	3,634	112,864		112,864	(3,936)	108,928			1
2	Food Purchase		75,158		75,158		75,158	(3,001)	72,157			2
3	Housekeeping	46,662	8,321		54,983		54,983	(12,046)	42,937			3
4	Laundry		946	14,261	15,207		15,207		15,207			4
5	Heat and Other Utilities			48,634	48,634		48,634	(10,714)	37,920			5
6	Maintenance	31,579	11,533	12,177	55,289		55,289	(13,155)	42,134			6
7	Other (specify):*											7
8	**TOTAL General Services**	180,974	102,455	78,706	362,135		362,135	(42,852)	319,283			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	476,522	27,138	14,357	518,017		518,017		518,017			10
10a	Therapy											10a
11	Activities	15,077	1,407	1,511	17,995		17,995		17,995			11
12	Social Services	16,135	190	1,511	17,836		17,836		17,836			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Ambulance Trips			557	557		557		557			15
16	**TOTAL Health Care and Programs**	507,734	28,735	29,936	566,405		566,405		566,405			16
	C. General Administration											
17	Administrative	46,674			46,674		46,674		46,674			17
18	Directors Fees											18
19	Professional Services			16,524	16,524		16,524		16,524			19
20	Dues, Fees, Subscriptions & Promotions			7,252	7,252		7,252	(3,773)	3,479			20
21	Clerical & General Office Expenses	35,979	4,129	10,207	50,315		50,315	(30)	50,285			21
22	Employee Benefits & Payroll Taxes			97,042	97,042		97,042		97,042			22
23	Inservice Training & Education			647	647		647		647			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation		2,585		2,585		2,585		2,585			25
26	Insurance-Prop.Liab.Malpractice			23,729	23,729		23,729		23,729			26
27	Other (specify):*											27
28	**TOTAL General Administration**	82,653	6,714	155,401	244,768		244,768	(3,803)	240,965			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	771,361	137,904	264,043	1,173,308		1,173,308	(46,655)	1,126,653			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LaHarpe-Davier Health Care Center #0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			42,552	42,552		42,552	(3,584)	38,968			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,534	30,534		30,534	(4,771)	25,763			32
33	Real Estate Taxes			1,118	1,118		1,118	(1,118)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			74,204	74,204		74,204	(9,473)	64,731			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		608		608		608		608			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			27,402	27,402		27,402		27,402			42
43	Other (specify):*	7,182		5,301	12,483		12,483	(11,355)	1,128			43
44	**TOTAL Special Cost Centers**	7,182	608	32,703	40,493		40,493	(11,355)	29,138			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	778,543	138,512	370,950	1,288,005		1,288,005	(67,483)	1,220,522			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,936)	1		4
5	Telephone, TV & Radio in Resident Rooms	(30)	21		5
6	Rented Facility Space	(975)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4	30		9
10	Interest and Other Investment Income	(4,771)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,773)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(54,000)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,483)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,483)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LaHarpe-Davier Health Care Center

ID# 0035741

Report Period Beginning: 10/01/2003

Ending: 09/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Expenses	$ (4,247)	43	1
2	Kid Care Revenue	(7,106)	43	2
3	Independent Living Utilities Cost	(6,541)	5	3
4	Independent Living Maintenance Cost	(7,436)	6	4
5	Independent Living Housekeeping Cost	(7,354)	3	5
6	Independent Living Meal Costs	(3,001)	2	6
7	Clinic Maintenance Costs	(4,744)	6	7
8	Clinic Housekeeping Costs	(4,692)	3	8
9	Clinic Utilities Costs	(4,173)	5	9
10	Non-Care Related Deprec	(3,588)	30	10
11	Non-Care Related Real Estate Taxes	(1,118)	33	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(54,000)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(3,936)	0	0	0	0	0	0	0	0	0	0	(3,936)	1
2	Food Purchase	(3,001)	0	0	0	0	0	0	0	0	0	0	(3,001)	2
3	Housekeeping	(12,046)	0	0	0	0	0	0	0	0	0	0	(12,046)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,714)	0	0	0	0	0	0	0	0	0	0	(10,714)	5
6	Maintenance	(13,155)	0	0	0	0	0	0	0	0	0	0	(13,155)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(42,852)	0	0	0	0	0	0	0	0	0	0	(42,852)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,773)	0	0	0	0	0	0	0	0	0	0	(3,773)	20
21	Clerical & General Office Expenses	(30)	0	0	0	0	0	0	0	0	0	0	(30)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,803)	0	0	0	0	0	0	0	0	0	0	(3,803)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,655)	0	0	0	0	0	0	0	0	0	0	(46,655)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **LaHarpe-Davier Health Care Center** **#** **0035741** **Report Period Beginning:** **10/01/2003** **Ending:** **09/30/2004**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,584)	0	0	0	0	0	0	0	0	0	0	(3,584)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,771)	0	0	0	0	0	0	0	0	0	0	(4,771)	32
33	Real Estate Taxes	(1,118)	0	0	0	0	0	0	0	0	0	0	(1,118)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,473)	0	0	0	0	0	0	0	0	0	0	(9,473)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(11,355)	0	0	0	0	0	0	0	0	0	0	(11,355)	43
44	**TOTAL Special Cost Centers**	(11,355)	0	0	0	0	0	0	0	0	0	0	(11,355)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,483)	0	0	0	0	0	0	0	0	0	0	(67,483)	45

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		X	CONSTRUCTION COSTS	N/A	04/07/76	$ 1,146,000	$ 592,013	04/07/16	5.0000	$ 29,576	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CASH FLOW		X	FIRST STATE BANK	Interest	11/20/03	30,000		06/02/04	6.9000	949	6
7	CASH FLOW		X	FIRST STATE BANK	Interest	09/23/04	29,000	2,202	09/23/05	6.9000	9	7
8												8
9	TOTAL Facility Related						$ 1,205,000	$ 594,215			$ 30,534	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,205,000	$ 594,215			$ 30,534	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaHarpe-Davier Health Care Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0035741

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,944 B. General Construction Type: Exterior BRICK Frame WOOD/STEEL Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HEALTH CARE		1992-1976	$ 34,133	1
2	LAUNDRY		1977	5,911	2
3	TOTALS			$ 40,044	3

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49			1977	$ 1,619,924	$ 22,715	Various	$ 22,717	$ 2	$ 1,344,778	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SINK UNIT			1979	860					856	9
10	NEW ROOF			1980	6,278					6,123	10
11	Patio /Sidewalk			1983	986					986	11
12	ROO REPAIRS, PHONE EQUIP			1984	11,617					11,617	12
13	ROOF, AC REPAIRS, WATER HEATER			1985	7,816					7,718	13
14	WATER HEATER			1986							14
15	REMODELING, ROOF REPAIRS			1987	31,941	1,063	Various	1,065	2	18,249	15
16	WINDOW REPLACEMENT			1988	715	36	20	36		599	16
17	DOORS, NURSING OFFICE ELEVATOR REPAIRS			1990	12,074	463	Various	463		11,040	17
18	NEW ROOF, DOOR & ALARM, AC TURF			1991	59,681	398	Various	398		58,633	18
19	MASONARY REPAIR, COMPRESSOR			1992	9,276	402	Various	402		4,897	19
20	NEW ROOF			1993	19,000		10			19,000	20
21	CARPET,ALARM, COMPRESSOR			1994	10,165	322	Various	322		8,779	21
22	WATER SOFTNER, SIDEWALKS, BLINDS			1995	4,716	275	Various	276	1	3,769	22
23	WINDOW GLASS			1996	1,428	72	20	71	(1)	606	23
24	FIRE ALARM			1997	3,340	334	10	334		2,422	24
25	REPLACEMENT DOOR			1996	1,096	55	20	55		430	25
26	BUILDING CARPET			1997	1,489		Various			1,489	26
27	FIXED EQUIPMENT			1998	11,452	844	Various	844		7,415	27
28	LAND IMPROVEMENT			1998	575	38	15	38		245	28
29	GAZEBO			2000	4,895	245	20	245		1,162	29
30	BOILER REPAIRS			2000	1,784	119	15	119		555	30
31	AIR CONDITIONER			2000	550	110	5	110		486	31
32	PATIO ROOF AWNING			2001	1,904	127	15	127		402	32
33	DAY CARE SIDEWALK			1999	800	53	15	53		270	33
34	SIDEWALK			2002	2,975	198	15	198		446	34
35	KID CARE REMODELING			2002	1,860	124	180	124		300	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,829,197	$ 27,993		$ 27,997	$ 4	$ 1,513,272	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 117,093	$ 10,745	$ 10,745	$	10	$ 70,554	71
72	Current Year Purchases	3,243	226	226		10	226	72
73	Fully Depreciated Assets	176,808				10	175,839	73
74								74
75	TOTALS	$ 297,144	$ 10,971	$ 10,971	$		$ 246,619	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Home Relalted	94 Ford Pick-up	1996	$ 10,000	$	$	$	4	$ 10,000	76
77	Nursing Home Relalted	90 Ford Van	1999	2,000				4	2,000	77
78										78
79										79
80	TOTALS			$ 12,000	$	$	$		$ 12,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,178,385	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,964	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,968	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,771,891	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental Property	$ 59,284	$ 2,576	$ 9,205	86
87	Clinic	22,629	1,012	20,684	87
88					88
89					89
90					90
91	TOTALS	$ 81,913	$ 3,588	$ 29,889	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 **Report Period Beginning:** 10/01/2003 **Ending:** 09/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 17,882	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	76,469		3
4	Supply Inventory (priced at fifo)	2,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,072		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Receivables	222		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 116,145	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	68,448		12
13	Land	91,985		13
14	Buildings, at Historical Cost	1,831,382		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	388,873		16
17	Accumulated Depreciation (book methods)	(1,801,780)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 578,908	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 695,053	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 17,319	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,202		29
30	Accrued Salaries Payable	37,551		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	14,376		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Insurance Withheld	(260)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 71,188	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	592,013		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 592,013	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 663,201	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,852	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 695,053	$	48

***(See instructions.)**

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 310,781	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 310,781	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(278,930)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (278,929)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 31,852	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 894,136	1
2	Discounts and Allowances for all Levels	(2,707)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 891,429	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	155	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,936	14
15	Telephone, Television and Radio	30	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	34	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	249	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,404	23
	D. Non-Operating Revenue		
24	Contributions	16,578	24
25	Interest and Other Investment Income***	4,771	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,349	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Aviery Income	360	28
28a	See List Attatched	91,533	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 91,893	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,009,075	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	362,135	31
32	Health Care	566,405	32
33	General Administration	244,768	33
	B. Capital Expense		
34	Ownership	74,204	34
	C. Ancillary Expense		
35	Special Cost Centers	13,091	35
36	Provider Participation Fee	27,402	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,288,005	40
41	**Income before Income Taxes (line 30 minus line 40)****	(278,930)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (278,930)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	472	480	$ 8,640	$ 18.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,483	6,316	112,257	17.77	3
4	Licensed Practical Nurses	6,290	6,754	97,044	14.37	4
5	Nurse Aides & Orderlies	34,080	35,699	254,741	7.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,561	1,662	15,077	9.07	9
10	Activity Assistants					10
11	Social Service Workers	1,649	1,753	16,135	9.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	432	480	6,720	14.00	14
15	Cook Helpers/Assistants	10,288	10,629	73,356	6.90	15
16	Dishwashers	3,242	3,372	22,657	6.72	16
17	Maintenance Workers	2,378	2,588	31,579	12.20	17
18	Housekeepers	8,191	8,462	46,662	5.51	18
19	Laundry					19
20	Administrator	2,024	2,068	46,674	22.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,024	3,529	35,979	10.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS Coord.	230	230	3,840	16.70	32
33	Other(specify) Kid Care	899	991	7,182	7.25	33
34	TOTAL (lines 1 - 33)	80,243	85,013	$ 778,543 *	$ 9.16	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	83	$ 3,634	1-3	35
36	Medical Director	Contract	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	985	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,511	11-3	44
45	Social Service Consultant	21	1,511	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	125	$ 19,641		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	34	$ 1,666	10-3	50
51	Licensed Practical Nurses	357	11,706	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	390	$ 13,372		53

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeff Howd	Administrator		$ 46,674
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 46,674

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wood Accounting	Accounting/Data Proc.	$ 4,552
McGladrey & Pullen, LLP	Audit/Data Proc.	4,100
Richard Rasmussen	Legal	21
Jill Thompson	Office Intern	1,000
Financial Adjustment Clinic	Collection Services	288
WDM Computer Services	Data Processing	6,563
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 16,524

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,385
Unemployment Compensation Insurance	6,132
FICA Taxes	58,883
Employee Health Insurance	1,247
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Fringe Benefits	1,394
Rounding	1
TOTAL (agree to Schedule V, line 22, col.8)	$ 97,042

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	921
Health Care Worker Background Check	1,053
(Indicate # of checks performed 51)	
Public Relations	3,773
Mes/IL	175
NAEIR	139
Il Hospital Association	1,093
IL Sec of State	83
Il Charity Bureau	15
Less: Public Relations Expense	(3,773)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,479

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LaHarpe-Davier Health Care Center **#** 0035741 **Report Period Beginning:** 10/01/2003 **Ending:** 09/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Il Hospital Assoc $1,903**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,103** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **27,402**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,936**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/a**
Attach invoices and a summary of services for all architect and appraisal fees.

LaHarpe Davier Healthcare Center, Inc.
#0035741
10/01/03 to 09/30/04

Allocation of Independent Living/Clinic Revenue
Page 5A Adjustments

Meals Served

Nursing Home	31858	96.01%
Independent Living	1325	3.99%
	33183	100.00%

Raw Food Cost $75,158.00

Nursing Home	$72,156.93
Independent Living	**$3,001.07 Line 6**

Square Feet

Nursing Home	23188	77.97%
Independent Living	4000	13.45%
Clinic	2552	8.58%
	29740	100.00%

Utilities Costs	$48,634.00
Housekeeping Costs	$54,678.00
Maintenance Costs	$55,289.00

	Utilities	Hskg	Maint.
Independent Living	**$6,541.22 Line 3**	**$7,354.14 Line 5**	**$7,436.31 Line 4**
Clinic	**$4,173.30 Line 9**	**$4,691.94 Line 8**	**$4,744.37 Line 7**

LaHarpe Davier Healthcare Center, Inc.
#0035741
10/01/03 to 09/30/04

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LaHarpe Davier Healthcare Center, Inc.
#0035741
10/01/03 to 09/30/04

Schedule V. Line 6, Column 3

Dietary Repairs/Maint	$118.73
Laundry Repairs/Maint	$128.00
Plant/Operation Outside Services	$1,143.24
Building Repairs	$1,791.82
Equipment Repairs	$2,835.79
Rent Exp.	$190.82
Cable TV	$462.59
Elevator Maintenance	$1,328.46
Refuse Expense	$3,412.44
Computer Repairs	$765.15
	$12,177.04

Schedule V. Line 21, Column 3

Telephone Expense	$6,275.82
Data Processing In-House	$71.85
Data Processing Support Costs	$3,859.47
	$10,207.14

Schedule V. Line 25, Column 2

Auto Repairs/Maint.	$2,203.44
Auto Gas/Oil	$339.31
Employee Mileage Reimbursement	$42.38
	$2,585.13

Schedule V. Line 43, Column4

Kid Care Salaries	$7,182.06
Kid Care Education	$53.66
Kid Care Food Exp.	$32.17
Kid Care Data Processing	$30.00
Kid Care Misc	$1,271.25
Kid Care Insurance	-$337.00
Misc Expense	$4,247.04
Contributions	$2.00
Rounding	$2.00
	$12,483.18

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Independent Living Revenue	$33,020.00
Guest Room Rental Income	$725.00
Clinic Rental Income	$13,450.00
Kid Care Income	$7,105.73
House Rental Income	$250.00
Gain on Sale of Asset	$14,564.99
Miscellaneous Income	$22,416.99
	$91,532.71

LaHarpe Davier Healthcare Center, Inc.

#0035741

10/01/03 to 09/30/04

LaHarpe Davier Healthcare Center, Inc.

#0035741

10/01/03 to 09/30/04

LaHarpe Davier Healthcare Center, Inc.

#0035741

10/01/03 to 09/30/04